24 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Birth Wt:	Wt:	%	Ht:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing **(by parent)** ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Feeds self ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Kicks a ball ☐ stacks 5-6 blocks ☐ 20 word vocabulary ☐ Walks up stairs/runs well ☐ Communicates needs in 2-4 word sentences ☐ Names 6 body parts Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sleep practices ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirection/praise ☐ read to child ☐ Car safety/booster seat/5 pt harness ☐ Learns 5-6 words every week ☐ Provide opportunities for success/choice: 2 items "juice or milk"/"red or blue shirt" ☐ Praise for effort/success ☐ Establish daily routine ☐ Encourage/support wide range of emotions ☐ Trike/bike safety ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Sense of humor ☐ Demonstrates increasing independence ☐ Plays alongside peers ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	[X] INDICATES ORDERED ☐ Blood Lead test **(perform at 24 months)** ☐ TB skin test **(if at risk)** ☐ Other
IMMUNIZATIONS:	[X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other
REFERRALS:	[X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007